

**Nebraska Health and Human Services System
Department of Regulation and Licensure, Credentialing Division**

Public Board Member Application Form

PLEASE PRINT OR TYPE

Name:	First	Middle	Last	Credentials (ie, PhD, etc., if applicable)
Mailing Address:	Street/Box/RR			
	City	State		Zip
Date of Birth:				
Are you a resident of the State of Nebraska?				Answer Yes or No
If yes, how many years have you been a NE resident?				
Business Telephone:		Cell/Pager:		
Residence Telephone:		FAX Number:		
E-Mail Address:				
Are you available to meet, usually in Lincoln, on a monthly basis, if necessary or required for Board Meetings?				Answer Yes or No
Please indicate how you became aware of this vacancy.				
Professional Association	HHS R&L Web Page		Newspaper	
Other (please explain): (Please use additional paper if space not adequate)				

ELIGIBILITY REQUIREMENTS

Please indicate the congressional district in which you are a resident:	1	2	3
Have you been a resident of your current congressional district for at least one year prior to this appointment?	Answer Yes or No		
Please specify how many consecutive years:			
Were you ever issued a health care license, certificate, or registration by the Nebraska Department of Health & Human Services Regulation & Licensure, or another State or Territory of the United States, or the District of Columbia?	Answer Yes or No		
If yes, please list the license type: (Please use additional paper if space not adequate)			
Do you have any immediate family or household members that are currently licensed or certified in a profession regulated by the Nebraska Department of Health & Human Services Regulation & Licensure?	Answer Yes or No		
If yes, please identify any immediate family or household members and their license type: (Please use additional paper if space not adequate)			
Are you an employee of someone who is currently licensed or certified in a profession regulated by the Nebraska Department of Health & Human Services Regulation & Licensure?	Answer Yes or No		
Please indicate your current and past involvement in community activities, including those related to health care: (Please use additional paper if space not adequate)			

Have you been involved in providing health care services in NE for any of the three years immediately prior to this appointment?			Answer Yes or No		
If yes, please specify the type of health care services. (Please use additional paper if space not adequate)					
Please indicate which of the following Boards you would be interested in serving on as a public member:					
<input type="checkbox"/>	Advanced Practice Registered Nurses	<input type="checkbox"/>	Hearing Aid Instrument Dispensing & Fitting	<input type="checkbox"/>	Pharmacy
<input type="checkbox"/>	Alcohol and Drug Counseling	<input type="checkbox"/>	Massage Therapy	<input type="checkbox"/>	Physical Therapy
<input type="checkbox"/>	Athletic Trainers	<input type="checkbox"/>	Medical Nutrition Therapy	<input type="checkbox"/>	Podiatry
<input type="checkbox"/>	Audiology & Speech-Language Pathology	<input type="checkbox"/>	Medicine and Surgery	<input type="checkbox"/>	Psychology
<input type="checkbox"/>	Chiropractic	<input type="checkbox"/>	Mental Health Practice	<input type="checkbox"/>	Respiratory Care
<input type="checkbox"/>	Cosmetology	<input type="checkbox"/>	Nursing	<input type="checkbox"/>	Veterinary Medicine
<input type="checkbox"/>	Dentistry	<input type="checkbox"/>	Nursing Home Administration	<input type="checkbox"/>	Physician Assistant Committee
<input type="checkbox"/>	Environmental Health Specialists	<input type="checkbox"/>	Occupational Therapy	<input type="checkbox"/>	No Preference
<input type="checkbox"/>	Funeral Directing and Embalming	<input type="checkbox"/>	Optometry	<input type="checkbox"/>	

EDUCATION			
School	Location	Degree/Specialty	Completed Date

WORK EXPERIENCE (List current or most recent position first)			
Type of Experience	Location	From/To	Average Number of Hours Per Week

ADDITIONAL INFORMATION	
Describe your interest in serving as a public member and why you wish to serve on a Professional Licensing Board: (Please use additional paper if space not adequate)	
Are you aware of any reason why your appointment might be considered a conflict of interest as defined in Title 172 NAC 3, Regulations Establishing Definitions of Conflicts of Interest for Members of the Boards of Examiners in the Health Professions? Answer Yes or No	
If yes, explain: (Please use additional paper if space not adequate)	
Are you currently under investigation? Answer Yes or No	

I swear and affirm that all information I have provided on this application is true and complete to the best of my knowledge.

Signature

Date

Return completed application to: Joyce M. Novak, Administrative Assistant,
Nebraska Department of Health & Human Services Regulation and Licensure,
Credentialing Division, Nebraska State Office Building, 301 Centennial Mall South, PO Box 94986, Lincoln, NE 68509-4986
(402) 471-0182; FAX (402) 471-3577